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Supreme Court, U.S.
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No. 92-2020

IN THE
Supreme Court of the United States
OCTOBER TERM, 1992

JONATHAN MARSH, a Minor,
by and through his Guardian Ad Litem,
Sharon Marsh,
Petitioner,
vs.
ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,
Respondent.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA welfare benefit plan expressly limits medical expense benefits to those expenses incurred while the group insurance policy which funds the plan is in force, and where Congress has expressly limited the requirement of "vested" benefits to pension plans, plan participants have a "vested" right to benefits for expenses incurred *subsequent* to the termination of the policy and the expiration of any extended benefit period, especially where the expenses stem from an accident occurring *prior* to the effective date of the policy?

2. Should this Court review the question whether, as a matter of federal common law, ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*, where the plan at issue is not ambiguous?

3. Should this Court review the question whether, where an ERISA welfare benefit plan expressly provides that a plan participant may elect to purchase conversion coverage which will be in accordance with applicable state law, and where state law provides for limited, minimum conversion benefits, that plan participants instead are entitled to the same level of benefits under the conversion policy as provided under the group insurance policy which funds the plan?

RULE 29.1 LISTING

1. Parents

Respondent Allstate Life Insurance Company of New York is a subsidiary of Allstate Life Insurance Company, Allstate Insurance Company, and Sears, Roebuck & Co.

2. Subsidiaries

Respondent Allstate Life Insurance Company of New York has no subsidiaries.

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No. 92-2020

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1992

JONATHAN MARSH, a Minor,
by and through his Guardian Ad Litem,
Sharon Marsh,
Petitioner,
vs.
ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,
Respondent.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent, Allstate Life Insurance Company of New York ("Allstate"), respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. The decision is unpublished.

STATEMENT OF THE CASE

A. Nature Of The Case

Petitioner commenced this action against Allstate to obtain benefits under the group insurance policy at issue for medical expenses incurred by him *after* his father

voluntarily terminated coverage under the policy for himself and his dependents, including Petitioner, *after* his father voluntarily prematurely terminated Petitioner's right to receive continuation benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C §§ 1161-1168 ("COBRA"), and *after* Petitioner's twelve month extension of benefits under the policy ran out.

Petitioner's claim is based on the concept of "vesting," a concept developed for accident and occurrence type insurance policies but having no application to medical expense policies, such as the policy at issue here. Moreover, even if the "vesting" theory were applicable here — and it is not — the accident or occurrence giving rise to Petitioner's alleged vested rights occurred over three years *before* the effective date of the Allstate policy. Indeed, the accident or occurrence took place when the insurance coverage of another insurer sued by Petitioner was in force. Accordingly, even if benefits "vested," they did not vest with respect to Allstate.

Faced with the fact that his coverage had been voluntarily terminated and that he was no longer insurable due to his serious medical condition, Petitioner brought this action under and pursuant to ERISA against Allstate and two other insurers which had previously insured the employee benefit plan at issue, the Equitable Life Assurance Society of the United States ("Equitable") and Travelers Insurance Company ("Travelers"). Petitioner, however, up to the present has only pursued his claims as against Allstate; the action has been stayed as against Equitable and Travelers pending final resolution of Petitioner's claims against Allstate.

B. Statement Of Facts

1. Petitioner's Coverage Under The Group Policy

Petitioner, the dependent son of Richard V. Marsh, an employee of Marsh Broadcasting, alleges that he suffered a serious accident in 1982 which rendered him totally disabled. [CR 1, ¶ 9.] By this lawsuit, he seeks payment of benefits for medical expenses incurred by him on or after May 1, 1990 and to be incurred by him in the future as a result of that 1982 accident.

Marsh Broadcasting provided medical expense insurance to its employees (and their dependents) by joining together with other companies to procure health insurance for their employees by association with Universal Broadcasting Corporation ("Universal"). Universal, in turn, procured insurance for the employees of its members from Equinet Small Group Network Trust ("Equinet"). [CR 1, ¶ 4.]

At the time of Petitioner's accident, in 1982, he was covered for and received benefits as a dependent under a policy issued by Equitable to Equinet. Subsequently, Equinet replaced the Equitable policy with a policy issued by Travelers. Equinet later replaced the Travelers policy with Allstate's Group Policy No. 64700289 (the "Group Policy"), issued to Equinet effective April 10, 1986. [CR 1, ¶ 4.]

Because Petitioner was receiving benefits under an extension of benefits pursuant to the policy issued by the predecessor insurer (Travelers), Allstate did not begin providing benefits to Petitioner until on or about January 1, 1988, almost six years after the swimming pool accident for which Petitioner seeks "vested benefits." [CR 1, ¶¶ 12, 13.]

Richard V. Marsh voluntarily terminated his (and Petitioner's) coverage under the Allstate Group Policy effective April 30, 1988. Mr. Marsh subsequently elected and Petitioner received continuation benefits pursuant to COBRA until April 30, 1989, when Mr. Marsh voluntarily terminated that coverage some six months before it otherwise would have expired.[1] [CR 29, p. 56, ¶ 3; 29 U.S.C. § 1162 (individual may elect up to 18 months of COBRA continuation coverage).] Then, after the voluntary termination of Petitioner's COBRA coverage on May 1, 1989, Allstate continued to provide benefits to Petitioner under the Extension of Benefits provision of the Group Policy. The extension expired on May 1, 1990. [CR 29, p. 56, ¶ 3.]

Richard V. Marsh elected to purchase conversion coverage for his family, including Petitioner, upon termination of his coverage under the Group Policy. [CR 29, pp. 33-34.]

2. The Group Policy Expressly Limits Benefits Payable To Those Expenses Incurred By An Insured While Coverage Is In Effect.

The Group Policy expressly limits the medical expense benefits available to "Eligible Expenses" incurred *while an individual is insured*:

---

[1] Although Petitioner claims that Allstate unilaterally terminated the group coverage [Petition, p. 5], there is absolutely no support in the record for this claim. Rather, as the District Court found, Mr. Marsh *voluntarily* terminated Petitioner's coverage under the Group Policy. [See, Petition, Appendix E, p. 38; CR 8, p. 34, ¶ 3.]

"MEDICAL BENEFIT

> The Medical Benefit is paid for Eligible Expenses *incurred* for an Injury or Sickness *while insured*." [CR 29, p. 69 (emphasis added).]

"Eligible Expense" is defined as meaning "the following types of Expense *incurred* for an Injury or Sickness *while insured* . . ." [CR 29, p. 71 (emphasis added).]

Further, the Group Policy defines "Expense" to mean:

> "a charge a person is legally obligated to pay. 'Expense' is deemed to be *incurred on the date the service or supply is furnished*. . . ." [CR 29, p. 82 (emphasis added).]

Finally, the Group Policy defines when coverage terminates as follows:

> "TERMINATION OF INSURANCE
>
> *EMPLOYEES' INSURANCE*
>
> Subject to the Continuance of Insurance provision, your insurance ends when the first of these events takes place:
>
> - the date the group policy . . . ends . . .
>
> The end of insurance will not affect any claim for a loss that took place while the insurance was in force. . . ."

A similar provision applies to dependents' insurance. [CR 29, pp. 64-65.]

Thus, the Group Policy provides benefits only for expenses incurred while coverage is in force; it does not provide benefits for expenses incurred after termination

of coverage, unless, as indicated below, the individual is entitled to continued or extended benefits.

3. The Group Policy Provides Extended Benefits Or Continued Benefits To Individuals In Certain Circumstances When Their Coverage Terminates.

The Group Policy provides additional, limited benefits to individuals who are totally disabled when their coverage would otherwise terminate.

In the case of the termination of the Group Policy, a one year extension of benefits is provided where an individual is totally disabled:

> "EXTENSION OF BENEFIT
>
> We will pay the Medical Benefit after a person's insurance ends, if:
>
> - the person is Totally Disabled on the day the insurance ends;
> - the person stays Totally Disabled until the *Expense is incurred*;
> - the *Expense is directly* related to the Total Disability;
> - the *Expense is incurred within 12 months after the day the insurance ends*; and
> - the person has not become insured by another group plan offering essentially the same coverages." [CR 29, p. 75 (emphasis added).]

Further, the Group Policy also provides that coverage may be continued if an employee is on a leave of absence or temporary layoff, for a period of no longer than six months. [CR 29, p. 65.]

And, regardless of whether coverage is extended or continued, the Group Policy provides a medical conversion privilege under which an insured whose coverage terminates because the Group Policy ends may elect to purchase an individual policy from Allstate without evidence of insurability. [CR 29, p. 81.]

4. The Group Policy Provides That Coverage May Be Converted To An Individual Policy Which Is In Accord With Applicable State Law.

The Group Policy provides that:

> "A person whose medical Expense Insurance ends may be eligible to buy health insurance coverage from us . . .
> "The form, benefits provided, premium and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." [CR 29, p. 81.]

Pursuant to an enrollment form submitted to it by Mr. Marsh, Allstate Life Insurance Company enrolled Mr. Marsh and his family, including Petitioner, under its policy number 64400200 effective May 1, 1989 (the "Conversion Policy"). [CR 29, p. 34, ¶ 6.]

Although Petitioner claims that Mr. Marsh "detrimentally relied" on the Group Policy's "implicit promise" that the Conversion Policy would provide benefits

equivalent to those provided under the Group Policy [Petition, pp. 36-44], there is no support in the record for this claim. Mr. Marsh did not even know that a conversion policy was available until informed by Allstate that it intended to terminate the extended benefits being provided to Petitioner. [CR 2, p. 21]. Thus, contrary to Petitioner's claims [Petition, p. 43], Mr. Marsh could *not* have relied on an assumption that the conversion coverage would be equal to the group coverage until *after* the termination of the group coverage.

C. The District Court's Decision

Based on the express terms of the policy, the District Court, construing the *entire* policy, held that the Group Policy expressly limits benefits to expenses incurred while the policy is in effect and that Petitioner does not have a right to "vested" benefits. It therefore granted Allstate's motion for summary judgment. [Petition, Appendix E.]

In ruling in favor of Allstate, the District Court correctly noted that while the concept of "vesting" typically arises in the context of accident or casualty policies, under which liability is triggered by a "happening" or "occurrence," the Allstate Group Policy is a medical expense policy, under which liability is triggered by the "accrual of a medical expense." [Petition, Appendix E, pp. 41-42.] Under medical expense policies, the Court held, "an insured's right to benefits does not 'vest' at the occurrence of an injury." [*Id.* at 42.] Moreover, the Court noted that "it would be illogical to hold [that] [Petitioner's] rights 'vested' with Allstate in 1982 when, in point of fact, Allstate was not even the carrier at the time of [Petitioner's] accident." [*Id.*]

With respect to the conversion policy issue, the District Court found that there was no evidence to support Petitioner's claim that Mr. Marsh relied on any portion of the Group Policy with respect to his understanding as to the scope and level of conversion benefits. [Petition, Appendix E, pp. 58-59.]

D. The Ninth Circuit's Decision

The Ninth Circuit, in an unpublished Memorandum Decision filed January 22, 1992, affirmed the District Court's decision.

In doing so, the Court, applying the normal rules of contract construction, interpreted the Group Policy as a whole and found that it "unambiguously precludes the vesting of benefits . . ." [Petition, Appendix A, pp. 10-11.]

The Court also rejected Petitioner's argument with respect to the Conversion Policy. The Court held that "nothing in the [Group] Policy implies that [Petitioner] . . . should receive the same benefits under the conversion policy as he did under the [Group] Policy"; that Petitioner "has pointed to nothing in the [Group] Policy that would have caused a reasonable person to draw such inference"; and that Petitioner "has [not] offered any evidence that he held such belief and relied on it." [Petition, Appendix A, p. 10.]

By order filed March 17, 1993, the Ninth Circuit denied Petitioner's petition for rehearing and rejected the suggestion for rehearing en banc. [Petition, Appendix B.]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

In the first question, Petitioner urges this Court to ignore the plain wording of the contract and do that which Congress has refused to do, *i.e.*, adopt a rule requiring "vesting" for employee welfare benefit plans. This case does not properly raise that question, however. Rather, as both the District Court and the Ninth Circuit recognized, the plan language at issue is very detailed, specific and unique and unambiguously precludes vesting. Moreover, even if the plan language were ambiguous — and it is not — the "loss" allegedly giving rise to Petitioner's alleged right to "vested" benefits took place some three and one-half years before the policy was in force. This Court should not review a question which turns on the alleged ambiguity of a plan which in fact is not ambiguous and which, even if read in Petitioner's favor, would not result in a finding of "vested" benefits under the facts and circumstances of the case.

Similarly, the second question also is not properly raised by this case. The rule of *contra proferentem* that Petitioner urges the Court to establish construes insurance policies such that ambiguities are construed against the insurance company. Again, since the policy at issue simply is not ambiguous, and, even if it were, would still not require a finding in Petitioner's favor, the Court need not reach this question.

Finally, via the third question, Petitioner would have this Court step in and rewrite not only the policy, but state laws regarding conversion policy benefits. The Court should not do so.

Thus, this case turns on the specific wording of a number of very detailed, specific and unique provisions in the insurance policy at issue. The inquiry is highly fact specific. Although the questions presented by the Petition are important to the parties, there is no public importance associated with their outcome and the questions are not of sufficient importance to warrant review by this Court.

I.

THE FIRST QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The first question presented by the Petition is whether where the Group Policy expressly limits medical expense benefits to those expenses incurred while the policy is in force, and where Congress has expressly required "vested" benefits only for pension plans, this Court should rewrite the Group Policy, override Congress' legislation in this area, and establish federal law providing for the "vesting" of benefits under welfare benefit plans. In essence, Petitioner would have the Court find ambiguity where none exists and rewrite ERISA in a manner in which Congress has refused.

A. ERISA Does Not Require The "Vesting" Of Welfare Benefits.

ERISA specifically draws a distinction between "employee *pension* benefit plans" (which provide pension benefits which, by definition, vest for future availability) and "employee *welfare* benefit plans" (which provide, among other things, medical expense

benefits during the period coverage exists). *Compare* 29 U.S.C. § 1002(1) *with* § 1002(2)(a). Congress included both pension and welfare plans in ERISA's reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, and standards of fiduciary conduct governing plan administration, 29 U.S.C. §§ 1101-4. ERISA, moreover, assures the protection of vested *pension* benefits by prescribing participation requirements, funding requirements, and vesting and accrual schedules, 29 U.S.C. §§ 1051-61, 1081-86, and by providing that an employee's right to his or her normal retirement benefit shall be "nonforfeitable," 29 U.S.C. § 1053(a). Congress, however, expressly *excluded* welfare plans from ERISA's participation and vesting and funding requirements. 29 U.S.C. §§ 1051(1), 1081(a).

As this Court stated in *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989):

> ". . . ERISA's vesting and funding requirements do not apply to welfare benefit plans . . ."

Similarly, in *West v. Greyhound Corp.*, 813 F.2d 951, 954 (9th Cir. 1987), the Court held that:

> "ERISA . . . expressly exempts employee welfare benefit plans from the sections concerned with vesting and accrual. 29 U.S.C. §1051(1). While ERISA, in 29 U.S.C. §1322, also guarantees the payment of all nonforfeitable benefits, this protection is applicable only to pension, stock bonus or profit-sharing plans. 29 U.S.C. §1321(a); 26 U.S.C. §401(a). *There is no language in ERISA which provides for the accrual of welfare benefits or guarantees that such*

> *benefits are vested or nonforfeitable.*"
> (Emphasis added.)

Numerous other courts have agreed that ERISA does not require the "vesting" of benefits under welfare benefit plans. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 491 (2nd Cir. 1988); *Turner v. Local No. 302, International Brotherhood of Teamsters, etc.*, 604 F.2d 1219, 1225 n.5 (9th Cir. 1979); *Coleman v. General Elec. Co.*, 643 F.Supp. 1229 (E.D. Tenn. 1986), *aff'd*, 822 F.2d 59 (6th Cir. 1987).

Accordingly, since ERISA does not require the "vesting" of medical expense benefits, "vesting" should not be read into a plan, as Petitioner attempts to do here, unless the plan explicitly and unambiguously so provides.[2] As discussed below, the plan at issue simply does not provide for the vested benefits Petitioner seeks. And, even if it did so provide, Allstate was not even the insurance carrier at the time of the accident or occurrence giving rise to Petitioner's alleged vested rights.

B. Petitioner Is Not Entitled To "Vested" Benefits Under The Terms Of The Group Policy.

Petitioner bases his claim to "vested" benefits on a reading of isolated phrases in the Group Policy. An analysis of the *entire* policy, however, reveals that Petitioner's claims are misplaced and that the Group Policy does not provide the "vested" benefits he seeks.

---

[2] Petitioner's claim that "[i]n the court below, Allstate argued that . . . vesting could not be applied to an employee welfare benefit plan" [Petition, p. 29] is incorrect. In fact, Allstate's argument in the Ninth Circuit on this score was identical to the position set forth by Allstate in this Brief in Opposition.

Under the express terms of the Group Policy, an individual is entitled to medical benefits only for expenses incurred while the policy is in force. In particular, the Group Policy provides:

> "The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness *while insured.*" (Emphasis added.)

The clear intent of this language was to provide coverage only with respect to expenses incurred while the policy was in force. That intent was further clarified by the provision of the Group Policy stating that an individual's insurance ends on the date of termination of the policy:

> "Your insurance terminates . . . the date the Group Policy . . . ends."

The phrasing of the Group Policy not only provides for benefits for covered medical expense charges incurred by an insured individual "while insured," but it also extends coverage beyond termination only for a limited time period, and only in limited circumstances, under the Extension of Benefits and Continuance of Insurance provisions.

Thus, when the Group Policy is read as a whole, it provides only for limited post-termination benefits. If Petitioner's claim that he is entitled, after termination of Group Policy coverage, to benefits for expenses incurred after termination, is correct, it would render the Extension of Benefits and Continuance of Insurance provisions meaningless.

In the face of this clear language, Petitioner contends that one phrase in the Group Policy, when viewed in isolation, provides him with a right to "vested" benefits.

The phrase upon which Petitioner relies is "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force."[3] According to Petitioner, this provision means that termination of the policy will not affect claims for eligible expenses incurred after the termination of the policy for injury or sickness that occurred while the policy was in force. [Petition, pp. 9-14.]

To reach this result, however, Petitioner would ignore those portions of the Group Policy limiting benefits to expenses incurred while the policy is in effect and limiting benefits available post-termination to continued and extended benefits. Indeed, it is submitted that even when viewed in isolation the provision at issue does not give rise to "vested" benefits. Instead, by its plain terms, the provision merely states that the termination of coverage will not affect *claims* for expenses incurred prior to policy termination. This reading is reinforced by the fact that the provision is found in the general, "Insuring Provisions" section of the policy, which applies to life and accidental death insurance benefits as well as to

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[3] Petitioner's claim that Allstate "itself admitted in its Opposition to the Preliminary Injunction [that] this [provision] is a classic 'vesting' provision" [Petition, p. 9], is nothing but wishful thinking. In fact, the record, which Petitioner has conveniently ignored throughout the Petition, indicates that Allstate merely observed that the provision in question refers to the situation where, under the "Accidental Death and Dismemberment Benefit" portion of the Group Policy, benefits are payable if the specific loss in question, *i.e.*, death or loss of a limb or an eye, occurs within 90 days of an accident. [See CR 8, p. 17, n.3.] Allstate made this observation because, as the District Court noted, in the context of an *accident* policy the event giving rise to liability is an accident or occurrence, whereas in *medical expense* policies, the "event" giving rise to liability is the incurring of medical expenses. [See Petition, Appendix E, pp. 41-43, pp. 62-63, endnote 6.]

medical expense insurance benefits. In this regard the provision operates, for example, to provide that accidental death benefits will be paid if the specific loss in question, *i.e.*, death or loss of limb or an eye, occurs within 90 days of an accident. [CR 29, p. 53.]

Petitioner attempts to subvert the plain language of the policy by inventing a new provision. Under Petitioner's "new and improved" version of the policy, even though the Group Policy requires that an expense be incurred "while insured" for benefits to be payable, the insured remains "insured" because benefits have "vested." [Petition, pp. 12-13.] This argument is pure sophistry. The very issue in this case is *whether* the insured remains "insured" because benefits have "vested." Petitioner attempts, by this tortured construction, to "overlook the obvious"; if insurance was still "in force" as he claims, this case would never have arisen.

Thus, under the express terms of the Group Policy, benefits are limited to those expenses incurred while the policy is in effect and during any period of extended benefits.

C. Allstate Has No Liability To Petitioner Even Under His Own Theory of "Vesting."

Even assuming, for the sake of argument, that Petitioner's construction of the Group Policy is correct, Allstate has no liability to Petitioner for "vested" benefits.

Again, the language which Petitioner claims gives rise to his "vested" rights is as follows:

> "[t]he end of insurance will not affect any claim for a loss that took place while the insurance was in force."

Here, the alleged "loss" at issue is Petitioner's 1982 swimming pool injury. That "loss" did not occur while the Group Policy was in force, but rather, some 3-1/2 years *before* the Group Policy was in force and during coverage by a prior carrier, which carrier is also a defendant in the action. As noted above, Allstate's Group Policy does not provide benefits for events occurring prior to the date it was in effect. If benefits have "vested," as Petitioner contends, then they have vested with respect to the carrier whose policy was in force at the time of the "loss," and not with respect to Allstate. This other carrier, in fact, is a named defendant in Petitioner's Complaint. [CR 1.]

D. Even State Law, Which Petitioner Urges The Court To Adopt As Federal Common Law, Does Not Impose A Vesting Requirement.

Not only does ERISA not impose a vesting requirement and not only does the Group Policy not provide for vested benefits, but even state law, which Petitioner urges the Court to adopt as federal common law [Petition, pp. 24-29], does not impose a vesting requirement.

California law, for example, expressly negates the existence of the "vested rights" which Petitioner claims. California Insurance Code section 10128.2, entitled "Extension of benefits; discontinuance of policy," provides a 12 month extension of benefits period for employees or dependents who become totally disabled while insured under the policy and who continue to be totally disabled upon the termination of the policy.

In addition, California Insurance Code section 12692 provides a 90-day extension of benefits period in certain circumstances where the section 10128.2 continuance is not applicable.

California law, therefore, expressly defines the post-termination benefits that an insurance company must make available to individuals when their group coverage terminates.

Further, although Petitioner claims that "[v]esting of medical and health insurance benefits has been adopted as a rule of law in numerous states" [Petition, p. 24], a review of the cases cited by Petitioner for this proposition reveals that they are based upon elements or factors not present here, *i.e.*, ambiguous policy language;[4] the reasonable expectations of the insured;[5] modifications of policy language to exclude or limit coverages of expenses stemming from illnesses or disease commencing under more expansive policy language;[6] policies insuring the individuals for *accidents* occurring during the policy period;[7] policies expressly providing that charges

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[4] *Wardlow v. Kalispell General Hospital*, 164 Mont. 59, 518 P.2d 1164 (1974); *Lutsky v. Blue Cross Hospital Service, Inc.*, 695 S.W.2d 870 (Mo. 1985); *Danzig v. Dikman*, 53 N.Y.2d 926, 423 N.E.2d 402, 440 N.Y.S.2d 925 (1981); *Myers v. Kitsap Physicians Service*, 78 Wash.2d 286, 474 P.2d 109 (1970); *Sparks v. Republic Nat. Life Ins. Co.*, 132 Ariz. 529, 647 P.2d 1127, *cert. denied*, 459 U.S. 1070 (1982).

[5] *Brown v. Blue Cross & Blue Shield of Mississippi, Inc.*, 427 So.2d 139 (Miss. 1983); *Myers v. Kitsap Physicians' Service, supra.*

[6] *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985); *Danzig v. Dikman, supra.*

[7] *Service Life Ins. Co. v. Branscum*, 243 Ark. 463, 352 S.W.2d 586 (1962).

incurred after termination would be covered;[8] and policies covering specific conditions beginning during the policy period.[9]

Indeed, one of the cases cited by Petitioner, *Fassio v. Montana Physicians' Service*, 170 Mont. 320, 553 P.2d 998 (1976), held that the rule of vesting was *not* applicable to a medical expense policy, such as the Group Policy involved in this case. In addition, while Petitioner lists the State of Texas as being a jurisdiction which has adopted vesting as "a rule of law" [Petition, pp. 24, 26], he fails to inform the Court of the Supreme Court of Texas' recent decision in *Forbau v. Aetna Life Ins. Co.*, 36 Tex.Sup.J. 607, 1993 Tex. LEXIS 22 (May 5, 1993), in which the court rejected plaintiff's argument that she was entitled to plan benefits beyond the one year extension of benefits period provided by the policy after cancellation of the policy.

Moreover, the vast majority of cases dealing with this issue have rejected Petitioner's "vesting" argument and have held that a group health insurer is *not* required to provide coverage in connection with expenses for *injuries suffered before* the policy is terminated where the *expenses are incurred after* termination. The courts' reasoning is generally premised on two factors, both of which are present here: (1) that such policies expressly state that coverage terminates on the date the policy terminates; and, (2) that the policies provide express provisions detailing the circumstances wherein coverage

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[8] *Erwin v. United Benefit Life Ins. Co.*, 70 N.M. 138, 371 P.2d 791 (1962); *Washer v. Continental Casualty Co.*, 418 S.W.2d 900 (Tex.App. 1967).

[9] *Blue Cross - Blue Shield of Alabama v. Turner*, 43 Ala.App. 542, 195 So.2d 807 (1966), *cert. denied*, 280 Ala. 709, 195 So.2d 814 (1967).

will be provided after termination of the policy, *i.e.*, an extension or continuation of benefits.[10]

Indeed, many courts base their conclusion that there is no "vested" right to continued coverage *solely* on the first factor.[11]

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[10] *See, e.g., Monninger v. Group Insurance Service Center, Inc.*, 494 So.2d 41 (Ala. 1986); *Blue Cross & Blue Shield of Florida, Inc. v. Van Every*, 495 So.2d 923 (Fla. App. 1986); *Mezzacappo v. Travelers Ins. Co.*, 523 So.2d 291 (La. App.), *cert. denied*, 531 So.2d 473 (La. 1988); *Pierrotti v. Life Ins. Co.*, 295 So.2d 826 (La.App.), *cert. denied*, 299 So.2d 790 (La. 1974); *Sonneman v. Blue Cross & Blue Shield*, 403 N.W.2d 701 (Minn.App. 1987); *Gamble v. Connecticut General Life Ins. Co.*, 55 A.D.2d 838, 390 N.Y.S.2d 326 (1976); *Guardian Life Ins. Co. v. Zerance*, 505 Pa. 345, 479 A.2d 949 (1984); *Forbau v. Aetna Life Ins. Co., supra; Northwestern National Life Ins. Co. v. Glenn*, 568 S.W.2d 693 (Tex.App. 1978); *Jones v. Mutual Liability Ins. Co.*, 336 S.W.2d 905 (Tex.App. 1960).

[11] *See, e.g., Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350 (8th Cir. 1985); *Thacker v. Arkansas Blue Cross & Blue Shield*, 761 F.Supp. 654 (W.D. Ark. 1991); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D.Va. 1988); *Altiere v. Blue Cross & Blue Shield*, 551 So.2d 290 (Ala. 1989); *Arkansas Blue Cross & Blue Shield, Inc. v. Foerster*, 38 Ark.App. 228, 832 S.W.2d 280 (1992); *Time Ins. Co. v. Williams*, 566 So.2d 14 (Fla.App. 1990); *Johnson v. G.A.B. Business Services, Inc.*, 165 Ga.App. 284, 300 S.E.2d 325 (1983); *St. Paul Fire & Marine Ins. Co. v. Purdy*, 129 Ga.App. 356, 199 S.E.2d 567 (1973); *Duckett v. Piedmont Southern Life Ins. Co.*, 118 Ga.App. 3, 162 S.E.2d 531 (1968); *Antley v. Blue Cross/Blue Shield, Inc.*, 515 So.2d 1314 (Fla.App. 1987); *Hebert v. Red Simpson, Inc.*, 544 So.2d 751 (La.App. 1989); *Le Blanc v. Travelers Ins. Co.*, 486 So.2d 828 (La.App. 1986); *Harrington v. Prudential Ins. Co.*, 477 So.2d 1272 (La.App. 1985); *Matherne v. Prudential Ins. Co.*, 362 So.2d 823 (La.App. 1978); *Holzberg v. Mutual Life Ins. Co.*, 104 A.D.2d 972, 480 N.Y.S.2d 765 (1984), *appeal dismissed*, 65 N.Y.2d 1025, 484 N.E.2d 668, 494 N.Y.S.2d 305 (1985); *Ewalt v. Mereen-Johnson Machine Co.*, 414 N.W.2d 28 (S.D. 1987); *Wulffenstein v. Deseret Mutual Benefit Assoc.*, 611 P.2d 360 (Utah 1980).

Accordingly, Petitioner's argument that this Court should adopt a "vesting" rule as federal common law for ERISA plans is fatally flawed. The express terms of the policy at issue, federal and state legislation and case law all do not provide Petitioner with the "vested" rights he implores this Court to establish. Further, even if the Court were to establish such a rule, it would not apply to Petitioner because the accident in question occurred prior to the effective date of Allstate's policy. The Court, therefore, should not review the first question.

II.

THE SECOND QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The second question presented by the Petition is whether as a matter of federal common law ambiguities in an insurance policy issued to an ERISA plan are to be construed under the rule of *contra proferentem*. Petitioner also appears to propose a different rule of construction for insured as opposed to self-funded ERISA plans, and perhaps state a third rule for claims under self-funded plans with stop-loss insurance coverage.

This question is not of sufficient importance to warrant review by this Court. Rather, this case does not properly present this question because, as noted above, there is no ambiguity in the plan at issue.

As shown below, Petitioner confuses the difference between rules of interpretation, which seek the parties' intent, and contract rules of construction, which are applied only if the intent cannot be determined. Under the law of trusts, which is incorporated in ERISA, the plan documents must be read by the plan administrator

not under the contract doctrine of *contra proferentem*, but in light of all the circumstances, including the settlor's intent. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989); *Restatement (Second) of Trusts*, § 164. The same is true under the law of contracts. *Restatement (Second) of Contracts*, §§ 212(1) and comment b, 202(1), 212(2); 3 Corbin, *Contracts*, §§ 542, 542A, 543, 579.

It is submitted that terms in ERISA insurance policies, just like terms in non-ERISA insurance policies, are to be interpreted in light of the settlor's intent and "in an ordinary and popular sense as would a [person] of average intelligence. . . . We will 'not artificially create ambiguity where none exists.'. . . 'If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.' " *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (citations omitted), quoting *Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985).

Contra proferentem is not applied under contract law except as a constructional tool of last resort when the parties' intent cannot be determined. *Taylor v. Continental Group*, 933 F.2d 1227, 1233-34 (3rd Cir. 1991); *Record Club of America, Inc. v. United Artists Records, Inc.*, 890 F.2d 1264, 1271 (2nd Cir. 1989); *see also, Lippo v. Mobil Oil Corp.*, 776 F.2d 706, 714 n. 15 (7th Cir. 1985); *Quad Constr., Inc. v. Wm. A. Smith Contracting Co.*, 534 F.2d 1391, 1394 (10th Cir. 1976). Judge (now Justice) Anthony M. Kennedy summed up this point as follows:

> "A rule for construing contracts against the author is not an alternative to construing it as the parties intended. It is to be applied after the

> court has inquired into the intent of the parties, and then only if its meaning remains uncertain."

Board of Trade v. Swiss Credit Bank, 597 F.2d 146, 149 (9th Cir. 1979).

Indeed, under any rule of interpretation, be it federal law, California law, or the law of some other jurisdiction, the Court must apply certain rules of interpretation to ascertain the intent of the parties to a contract *prior* to using a rule of construction, such as the one resolving ambiguity against the drafting party. *See, e.g.*, California Civil Code §§ 1636, 1654. These rules require the Court to construe the contract as a whole, not in isolated parts, so as to give effect to every provision. *See, e.g.*, California Civil Code § 1641. Whenever reasonably possible, meaning must be given to every sentence, clause and word, so as to avoid rendering parts of a policy inoperative. *Holz Rubber Co. v. American Star Ins. Co.*, 14 Cal.3d 45, 533 P.2d 1055, 120 Cal.Rptr. 415 (1975). A construction which would give effect to one sentence of a policy, but completely ignore an entire paragraph dealing with the same subject matter, is *not* required by the rule, espoused by Petitioner, that an insurance policy should be liberally construed in favor of the insured. *Henricks v. Metropolitan Life Ins. Co.*, 7 Cal.2d 619, 631, 61 P.2d 1162 (1936).

The proper application of the rules of contract interpretation leads to the conclusion that Petitioner has no right to benefits under the Group Policy for expenses incurred by him after termination of coverage.[12]

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[12] It is especially important that these rules be applied in determining whether medical expense benefits "vest" under employee welfare benefit plans. It would be anomalous to utilize state common law rules of construction to bring in, via the "backdoor," a mandated

(continued)

Indeed, the terms of the Group Policy are not even ambiguous under the very case relied on by Petitioner for this proposition, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990). Even the *Kunin* court recognized that the rule of *contra proferentem* is applied only "if after applying the normal principles of contractual construction, 'the insurance contract is fairly susceptible of two different interpretations . . .' " *Id.* at 539 (citation omitted). Moreover, the *Kunin* court itself proceeded to analyze the entire policy at issue in that case, not just an isolated phrase or phrases, *id.* at 541, as Petitioner would have this Court do here. Only because it determined that it could not cure the ambiguity of a term by reference to the plan as a whole did the *Kunin* court apply the rule of *contra proferentem*. [*Id.* at 541.]

In his attempt to somehow, someway, obtain a benefit for which he did not bargain and which Congress refused to grant, Petitioner ignores this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that in construing the terms of the policy, the Court must seek out the intent of the trustor. The Court should not, as Petitioner urges it to do, construe the policy in an effort to find ambiguities where none exist and to construe them against the drafter. The Court may not prefer one party's interpretation over that of another.

What Petitioner is really seeking is the right to ignore both well-established state common law rules of contract interpretation and this Court's rules regarding the construction of ERISA plans and instead read an isolated word or phrase in a group insurance policy in isolation from and in conflict with the rest of the agreement.

(fn. continued)
vesting requirement which Congress itself rejected. The Court should not utilize preempted state law rules to rewrite ERISA.

The Court should not review the second question, which is not properly presented by this case.

III.

THE THIRD QUESTION DOES NOT PRESENT A QUESTION WHICH SHOULD BE REVIEWED BY THIS COURT

The third question presented by the Petition is whether the Court should step in and rewrite the policy and state law providing for limited, minimum conversion benefits to provide Petitioner with the same level of benefits provided under the Group Policy.

This question does not involve a federal question, let alone a split among the circuits or a question of general importance, to warrant review by the Court under Supreme Court Rule 10.1.

Quite simply, it is undisputed that the Group Policy meets the requirements of California law with respect to conversion policies. California law does not require a conversion policy to provide the same or similar benefits as does the group policy providing the right to convert.[13] Rather, the legislature made a policy decision — as it did with the vesting issue — that only a minimum level of benefits is required to be provided under conversion policies. *See*, California Insurance Code §§ 12670 (Legislature's intent to ensure that persons converting from group to individual policies "have access to minimum benefits" under the converted

[13] Mr. Marsh admits that he understood that Allstate would provide the minimum benefits required by California law. [CR 31, p. 3, ¶ 5.]

policy); 12684 (providing for minimum conversion benefits). Those minimum levels have been met here. *Compare* CR 1, pp. 41-42 and CR 29, pp. 40-49, *with* California Insurance Code § 12684.

Further, Congress, as a matter of federal law, has provided, in certain circumstances, that ERISA plan participants may continue the coverage provided by the group policy for up to eighteen months. 29 U.S.C. §§ 1161-68. In addition, plan participants have "the option of enrollment under a conversion health plan *otherwise generally available* under the plan" when such continuation coverage expires. 29 U.S.C. § 1162(5) (emphasis added). If Congress wished to impose a further requirement that such continuation coverage be made available for a longer period of time, or that the "conversion health plan" available under the group policy funding the plan offered the same level of benefits as did the group policy, it could easily have done so.

Accordingly, this Court need not review the third question.

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions of limited significance because they were resolved against Petitioner by both courts below based upon the particular and highly unique facts of the case. When these facts are analyzed, it is clear that the terms of the policy itself, statutory law and decisional law simply do not provide Petitioner with the right to vested benefits he seeks.

The Petition is nothing more than a last-gasp effort by Petitioner to have this Court step in, rewrite the policy, and do what both Congress and the California legislature

have refused to do in requiring that employee welfare benefits "vest" and that conversion policies provide the same level of benefits as the group policies providing the right to convert. The Petition, therefore, should be denied.

DATED: July 13, 1993.

Respectfully submitted,

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APPENDIX

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STATUTES

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2) (A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program —

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating benefits under the plan or the method of distributing benefits from the plan. . . .

29 U.S.C. § 1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii),

the date which is 18 months after the date of the qualifying event. . . .

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

California Insurance Code § 10128.2. Extension of benefits; discontinuance of policy

Every policy containing a life insurance benefit shall contain a reasonable extension of such benefit upon discontinuance of the policy with respect to employees who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. Every policy containing a loss of time benefit, or a hospital, medical, or surgical expense benefit shall contain a reasonable extension of such benefits upon discontinuance of the policy with respect to employees or dependents who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. . . .

(d) Every policy providing hospital, medical or surgical benefits on an expense-incurred or service basis shall be deemed to include a reasonable extension of such benefits upon discontinuance of the policy if it provides benefits for covered expenses directly relating to the condition causing total disability existing at the time premium payments for the employee or dependent

cease and incurred during a period of not less than 12 months thereafter, which period shall not be interrupted by discontinuance of the policy.

That extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that employee or dependent without limitation as to the disabling condition.

(e) The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy.

California Insurance Code § 12670. Legislative intent

It is the intent of the Legislature to ensure that persons covered by a group policy, who become ineligible for such coverage have access to minimum benefits pursuant to this part by requiring employers, employee organizations, and other entities which provide such coverage to their employees or members to also make available conversion policies for such persons and to ensure that insurers as herein defined offer conversion policies. In addition, it is the intent of the Legislature to encourage the continuation of group health coverage by requiring the entities herein defined to make available continuation benefits for widows, widowers, divorced spouses, and dependents who were covered by the group policy on the date of termination of coverage.

California Insurance Code § 12684. Major medical group coverage; minimum conversion benefits

Subject to the provisions and conditions of this part, if the group policy from which conversion is made provides the employee or member with major medical or comprehensive medical insurance, the employee or member shall be entitled to obtain a converted policy providing comprehensive medical coverage providing at least the following benefits:

(a) A payment per covered person for all covered medical expenses incurred during the person's lifetime equal to one hundred thousand dollars ($100,000); provided, however, that for treatment of mental illness payment may be limited to ten thousand dollars ($10,000) during the person's lifetime.

(b) Payment of benefits at the rate of 75 percent of covered medical expenses; provided, however, that if coverage is provided for expenses incurred for outpatient treatment of mental illness, payment of benefits may be at the rate of 50 percent of such covered expenses, and the insurer may limit the amount of covered expense for each outpatient visit and the amount of benefits payable for expenses incurred during each calendar year for that outpatient treatment.

(c) A cash deductible for each benefit period at the option of the insured of two hundred dollars ($200), five hundred dollars ($500), or one thousand dollars ($1,000), but not less than the cash deductible which applied to the insured under the group policy which entitles him or her to a converted policy.

(d) Covered medical expenses shall include the charges for a semiprivate hospital room and board, but need not exceed the lesser of one hundred fifty dollars ($150) per day or the hospital's most common charge for a semiprivate room, covered expenses for

intensive care shall be at least two and one-half times the covered hospital room and board charge. The maximum dollar amount for hospital room and board daily covered expense may be redetermined by the commissioner as to conversion coverage issued after the redetermination. That redetermination shall not be made more often than once in three years. The maximum dollar amount redetermined by the commissioner shall not exceed the average semiprivate room rate then charged in the state.

(e) Covered expenses under this section shall include benefits for expense incurred by the employee, member, or spouse in connection with pregnancy, provided that:

(1) The pregnancy commenced while covered under the group policy from which conversion was made;

(2) The expense is of a type which would have been covered under such group policy; and

(3) The conversion policy is in force when the expense is incurred.

(f) Covered expense under this section need not include expense for dental or vision care, or other optional benefits not normally offered by the insurer under a major medical or comprehensive medical expense plan.

California Insurance Code § 12692. Continuation benefit coverage; duration; eligible dependents; conditions of availability of coverage

On and after January 1, 1985, every insurer and nonprofit hospital service plan issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer to group policyholders a continuation benefit which if selected, shall have a duration of at

least 90 days and which shall be offered consecutively to any federal requirement for continuation benefits. The terms and conditions shall include continuation benefit coverage for widows, widowers, divorced or legally separated spouses, spouses of covered employees becoming entitled to benefits under Title XVIII of the Social Security Act, and their dependents, including dependent children who cease to be dependent children under the plan, who were covered by the group contract on the date of termination of coverage. However, any existing provisions of law regarding termination of a dependent child status shall not be affected by this section.

The continuation of coverage shall be available only under the following conditions:

(a) Those eligible remain within the State of California, although the departure of a dependent child to another state shall not invalidate the continuation provisions for any other family members.

(b) Those eligible do not marry or remarry, although the marriage of any dependent child shall not invalidate the continuation provisions for other family members.

(c) Those eligible are not eligible for any comparable state, federal, or private group medical plan, although the eligibility of any dependent child shall not invalidate the continuation provisions for other family members.

(d) Those eligible do not find employment with an employer that has a group plan of its own, even if the plan is less substantive, although the entry into such an employee plan by a dependent child shall not invalidate the continuation provisions for other family members.

(e) The group policy is not terminated or the employer's participation in the group policy is not terminated.

(f) Those eligible do not knowingly furnish incorrect information or otherwise improperly obtain the benefits of the plan.

(g) The continuing individual shall pay the premium amount in the manner specified in the group policy for both his or her share of the premium and the group policyholder's share, if any.

(h) Eligible persons under this section shall be notified in the same manner required for conversion notification pursuant to Section 12689. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.